Cartilage Shield Tympanoplasty in Children

Review of 268 Consecutive Cases

Jérôme Nevoux, MD; Gilles Roger, MD; Pierre Chauvin, MD, PhD; Françoise Denoyelle, MD, PhD; Erea Noel Garabédian, MD

Objective: To assess the efficacy of partial ossicular chain reconstruction using autologous cartilage.

Design: Prospective study (April 1, 1997, through January 1, 2008).

Setting: Tertiary academic children’s hospital.

Patients: Two hundred forty-eight children (268 ears) underwent partial ossicular chain reconstruction using a shaped block of tragal cartilage interposed between the head of the stapes and an underlay tympanic membrane reconstruction along with tragal cartilage and its perichondrium.

Main Outcome Measures: Anatomical and audiological results were evaluated according to the American Academy of Otolaryngology–Head and Neck Surgery guidelines. χ² Tests and multivariate analysis were used for statistical evaluation.

Results: Mean age at surgery was 10.9 years. Single-stage surgery was performed in 124 ears (46.3%) (62.9% for cholesteatomas and 32.3% for retraction pockets). Second-look patients (53.7%) included 93.8% of staged surgery. Audiometric results were available for 222 ears at 1 year and for 78 ears at 5 years. Closure of the average air-bone gap (ABG) to within 20 dB was achieved in 62.2% of ears at 1 year. The mean (SD) preoperative and 1-year postoperative ABGs were 25 (11.8) dB and 18.9 (10.3) dB, respectively. Anatomical results were satisfactory in 87.3%. No cases of extrusion, resorption, or displacement of the cartilage were encountered. No statistically significant difference was found between audiomeric results at 1 and 5 years. Multivariate analysis showed a significant negative correlation between preoperative and postoperative otitis media with effusion and postoperative ABG (P <.05).

Conclusions: Cartilage ossiculoplasty is a reliable technique for partial ossicular replacement. Long-term hearing outcomes remain stable and satisfactory. Preoperative and postoperative otitis media are the predictive factors of the hearing outcome.

failure: 2 perforations, 3 retraction pockets, and 4 recurrent cholesteatomas. The cholesteatomas and retraction pockets were localized on the edge of the cartilage for all but 1 ear, which had cartilage failure (Table 1).

**AUDIOMETRIC CRITERIA**

The audiometric criteria used were those of the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS). Auditory results were considered good for a postoperative, pure-tone, average air-bone gap (PTA-ABG) of 20 dB or less and excellent for a PTA-ABG of 10 dB or less. Air conduction gain rather than closure of the ABG was compared at each audiometric session (1, 2, 5, and 5 years postoperatively) and by grouping ears according to their successive audiometric results.

**ANATOMICAL CRITERIA**

The AAO-HNS guidelines considered the status of the ossicular chain, in particular of the stapes and malleus and, notably, the presence or absence of its handle. Ossicle lesions were classified into 2 groups following the Austin-Kartush classification: malleus handle present and intact stapes, malleus handle absent and intact stapes. Finally, the 2 postoperative criteria were postoperative OME and tube insertion.

**PREDICTIVE FACTORS**

The preoperative criteria studied were indication for surgery (primary cases: perforation, retraction pocket, or cholesteatoma; secondary cases: staged or revision for perforation, retraction pocket, residual lesion, or recurrence), type of surgery (primary or secondary), mean preoperative PTA-ABG, number of tube insertions, and opposite otoscopy. Perioperative criteria were state of the middle ear mucosa (inflammatory or not) and reconstruction of the scutum and ossicular chain status (Austin-Kartush classification) and malleus handle present and intact stapes, malleus handle absent and intact stapes. Finally, the 2 postoperative criteria were postoperative OME and tube insertion.

Auditory result stability (mean postoperative PTA-ABG) was analyzed as a function of time: mean postoperative PTA-ABG was compared at each audiometric session (1, 2, 5, and >5 years postoperatively) and by grouping ears according to their successive audiometric results.

**STATISTICAL ANALYSIS**

Anatomical results in function of type of surgery were compared using a $\chi^2$ test ($P < .05$). Distributions of quantitative data have been compared using an analysis of variance test or a non-parametric Kruskal-Wallis test when the distributions were not normal. Associations between potential predictive factors and auditory results have been studied using the $\chi^2$ test (or the Fisher exact test when numbers were small). All the factors associated with a $P < .20$ were introduced in a logistic regression model and then were backward selected to keep factors associated with a $P = .05$.  

Table 1. Characteristics of 268 Ears That Underwent Partial Ossicular Chain Reconstruction Using Cartilage Plates

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Cholesteatomas</th>
<th>Retraction Pockets</th>
<th>Perforations</th>
<th>Nonstaged Surgery</th>
<th>Staged Surgery</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>78 (62.9)</td>
<td>40 (32.3)</td>
<td>6 (4.8)</td>
<td>NA</td>
<td>NA</td>
<td>124 (46.3)</td>
</tr>
<tr>
<td>Secondary</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>9 (6.2)</td>
<td>135 (93.8)</td>
<td>144 (53.7)</td>
</tr>
</tbody>
</table>

Abbreviation: NA, not applicable.
AUDIOMETRIC RESULTS OVER TIME

At 1 year, 222 ears had audiograms (82.8% of 268 operated-on ears); at 2 years, 149 (55.6%); and at 5 years, 78 (29.1%). Good results were found for 62.2% of the 222 1-year audiograms, 57.0% of the 149 2-year audiograms, and 68.0% of the 78 5-year audiograms. Overall results were excellent in 21.6% of cases at 1 year (48 of 222), 20.8% at 2 years (31 of 149), and 28.2% at 5 years (22 of 78). Ninety-one of the 138 good 1-year results had a 2-year audiogram, with good results in 79.1% (72 of 91). Forty-one of the 72 good 2-year results had a 5-year audiogram, with good results in 82.9% (34 of 41). Mean (SD) air conduction gain at 1 year was 5.76 (13.59) dB (range, −30 to 49.25 dB). Mean (SD) PTA-ABG improved from 25 (11.8) dB preoperatively to 18.9 (10.3) dB at 1 year. In 35.1% of ears (78 of 222) with 1-year audiograms, surgery impaired hearing by a mean (SD) of 8.3 (6.4) dB.

For the 9 patients who underwent surgery because of failure, the mean PTA-ABG is 19.75. A nonparametric statistical analysis did not show any difference between these 9 cases and the 135 staged surgical procedures. There were 7 cases of severely decreased bone conduction or opera-tive hearing damage (postoperative bone conduction at 4 kHz – preoperative bone conduction at 4 kHz > 20 dB), but the differences in average bone conduction threshold and mean bone conduction at 4 kHz between preoperative and postoperative at 1 year were not significant. No dead ears were encountered postoperatively. Table 2 and Table 3 present results with comparisons between primary and secondary surgery.

The number of cartilage plates positioned between the stapes head and the subtympanic membrane cartilage had no effect on functional results. Good postoperative results did not differ between primary and secondary surgery (P = .07). We did not revise any cases for poor hearing. Concerning the revision cases due to failure, we did not notice any difference in auditory results. The mean PTA-ABG at 1 year was 19.75 dB.

ANATOMICAL RESULTS

In 14 years, there were no cases of cartilage plate extrusion or resorption; resorption was checked on follow-up otoscopy in all the cases and on computed tomographic control in some and was confirmed peroperatively in the case of secondary surgery. Secondary surgery found significantly fewer cases of middle ear inflammation, although the rate of malleus handle lysis was unchanged. Anatomical results were improved in the secondary surgery, independently of functional result (Table 4).

STABILITY OF RESULTS OVER TIME

Pairwise comparison of good results (overall cohort mean PTA-ABG) at each audiometric check showed no significant difference. Ears were classified according to successive audiometric results (good, bad, or missing), and evolution of hearing was studied for each ear. In 199 of the 222 ears (89.6%) with postoperative audiograms, the 1-year result, whether good or bad, was stable on subsequent controls. The other 23 cases (10.4%) showed varied patterns of evolution, but the small numbers involved precluded significant findings in one way or another in terms of improvement or degradation. It can, thus, be said that 1-year results proved stable at 3 years in most ears.

FACTORS PREDICTIVE OF GOOD AUDITORY RESULTS

Factors predictive of mean postoperative PTA-ABG were sought at 1-year follow-up. Univariate analysis of the
1-year results identified 2 prognostic factors: mean preoperative PTA-ABG (in 10-dB steps) \( (P = .002) \) and postoperative OME or tube insertion \( (P = .03) \). No other preoperative, perioperative, or postoperative variables were predictive of auditory results.

In multivariate analysis, these 2 factors were still correlated with mean postoperative PTA-ABG at 1 year. A 10-dB increase in mean preoperative PTA-ABG reduced the probability of a good postoperative result 1.62-fold (odds ratio, 0.62; 95% confidence interval, 0.49-0.78). Independently of this, postoperative OME or tube insertion reduced the probability of a good postoperative result 3.06-fold (odds ratio, 0.33; 95% confidence interval, 0.12-0.87). Results could be extrapolated beyond that date because functional results did not significantly vary with time. Multivariate analysis results at 2- and 5-year follow-up confirmed results at 1 year, especially for the prognostic value of a preoperative PTA-ABG increase.

The present technique consists of superimposing a cartilage fragment or fragments freed of perichondrium on both sides. The number of fragments depends on the depth of the cavity and does not affect the functional result. The advantage lies in the absence of perichondrium between the fragments, providing a more rigid assembly and, thus, less energy loss in sound transmission. In most cases, just 1 supplementary fragment is enough. The large reinforcement plate reduces cavity depth, especially between the stapes head and the tympanic membrane. There is serious risk of postoperative tympanic membrane retraction in children, further reducing cavity depth, and the choice of ossiculoplasty material needs to consider this. The advantage of cartilage is that it allows the ossiculoplasty to be tailored exactly to cavity depth. Adaptation using the incus is more difficult, with a risk of ossicular fracture during drilling. Partial prostheses, finally, have an irreducible minimum size and cannot be so easily used.

The literature analysis revealed much missing information, hindering rigorous comparison. Cohort patient data were never complete. In 3 studies, patient age was not reported despite the fact that severity varies with age. Apart from the present study, only the study by Harvey and Lin included a substantial number of children. It is difficult to find data about initial pathologic abnormalities, even when they are available. It seems to have been much less severe in the series of Malafronte than in that of Harvey and Lin or the present study. Audiometric follow-up also varied. The earliest studies (Aitken and Sheehy and Luejt and Denninghoff) gave results at 6 months, which is far too early to assess stability over time. Finally, none of the studies reported mean preoperative PTA-ABG and gain or mean postoperative air conduction. Neither was the hearing threshold calculation explained except by Malafronte et al and Harvey and Lin, who followed AAO-HNS guidelines.
In brief, there is lack of homogeneity in the methods for reporting results of type III tympanoplasty using a cartilage plate. The study by Harvey and Lin\(^\text{27}\) was the most complete and the closest to the present findings, with, however, much shorter follow-up and a smaller cohort.

The incus, sculpted and positioned between the malleus handle and the stapes head, can be used to restore the ossicular chain. The few, and old, child studies\(^\text{18,19}\) reported results scarcely different than those for cartilage plates. The percentage of good results was nearly 60% to 65%. The mean postoperative PTA-ABG was approximately 20 dB. Inner ear impact was slight, as in the present study (approximately 3%). Extrusion rates using the incus, on the other hand, which varied from 3% to 17%, were greater than with cartilage plates, where they would seem to be zero.\(^\text{20,21}\) At 15-year follow-up, Hall and Rytzner\(^\text{22}\) found no incus resorption.

There are few studies of partial ossicular replacement prostheses (PORPs)\(^\text{23-25}\) in children, and their data are not always usable. Cohorts usually combined children and adults without distinction. Thus, the House Clinic study\(^\text{24}\) included a large number of children (25%) in a large cohort. Results reported by Daniels et al\(^\text{25}\) in 1998, in a purely pediatric cohort, were similar to those found in adults. In 1986, Silverstein et al\(^\text{21}\) reported auditory results after incus transposition comparable with those obtained with PORPs. This was not confirmed by Rondini-Gilli et al\(^\text{20}\) in 2001, who reported better results with the porous polyethylene (Plasti-pore; Plastipore, Fountain Valley, California) prosthesis than using the incus.\(^\text{20}\) Conversely, the Portmann Institute team\(^\text{26}\) reported better results with incus transposition. The auditory results in the present study were better than those reported for PORPs. In 2001, Iurato et al\(^\text{23}\) demonstrated stable hearing results over time with PORPs, as with cartilage plates in the present series. Extrusion rates when prostheses are not covered by a cartilage plate are close to those found with incus transposition at 4% to 21%.\(^\text{27}\) Extrusion with cartilage reinforcements is, in contrast, rare (1.9%).\(^\text{3,28}\)

The choice of ossiculoplasty material should be founded on precise criteria. Assembly time needs to be taken into account because it varies considerably between techniques; it seems to be longest in the case of the incus, which needs sculpting—shorter with cartilage and shortest with prostheses. Cartilage is readily available in large quantities and with varying thicknesses (tragus and conchae) to allow precise adaptation to individual middle ear anatomy. Moreover, it is cost free, durable, and free of risk of absorption or extrusion, all combining to make it a material of choice. Furthermore, using the incus in the case of cholesteatomas entails a risk of residual lesion due to residual ossicle epidermal fragments.

In conclusion, the present study demonstrated the efficacy of type III tympanoplasty using cartilage plates to reconstruct the ossicular chain in children. Functional results were good (postoperative PTA-ABG ≤ 20 dB) in approximately 60% of cases, matching results reported with other materials, and there is a trend toward stability over time at more than 5 years of follow-up. Anatomical results were very satisfactory in 80% of cases. Predictive factors for results were mean preoperative PTA-ABG and postoperative inflammation (postoperative OME or tube insertion). The prime factor determining the result of ossiculoplasty is the causal pathologic abnormality and not which material is used.

After comparison with literature reports for other materials, this study validates (1) cartilage ossiculoplasty associated with shield tympanoplasty in children, (2) the use of cartilage for ossiculoplasty where the stapes is associated with shield tympanoplasty in children, (2) the use of cartilage for ossiculoplasty where the stapes is associated with shield tympanoplasty in children, and (3) stability of results in the medium and long term.

Submitted for Publication: April 2, 2010; final revision received June 8, 2010; accepted July 25, 2010.

Correspondence: Jérôme Nevoux, MD, Service d'Otorhinolaryngologie et de Chirurgie Cervico-faciale, Hôpital d'Enfants Armand-Trousseau, 26 rue du Dr Arnold Netter, 75012 Paris, France (jerome.nevoux@trs.aphp.fr).
Author Contributions: All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Nevoux, Roger, Chauvin, Denoyelle, and Garabédian. Acquisition of data: Nevoux. Analysis and interpretation of data: Nevoux, Roger, and Chauvin. Drafting of the manuscript: Nevoux and Roger. Critical revision of the manuscript for important intellectual content: Nevoux, Roger, Chauvin, Denoyelle, and Garabédian. Statistical analysis: Roger and Chauvin. Administrative, technical, and material support: Nevoux and Roger. Study supervision: Nevoux, Roger, Denoyelle, and Garabédian.

Financial Disclosure: None reported.

Previous Presentation: This study was presented at the American Society of Pediatric Otolaryngology Annual Meeting; May 2, 2010; Las Vegas, Nevada.

REFERENCES

16. Luetje CM, Denninghoff JS. Perichondrial attached double cartilage block: a better alternative to the PORP. Laryngoscope. 1987;97(9):1106-1108.